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A cigar please!

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Blackground:
HTA, SAOS, intermittent claudication;Toxics:smoker 40pack/year.
A 78-year-old male who went to the emergency room for right palpebral ptosis of sudden onset 3 days after coughing episode.
Exploration. Conscious collaborator and oriented. TA 130/67mmHg, FC 90bpm. Rhythmic heart and pulmonary auscultation not pathological.
Neurological examination: isocoric and normoreactive pupils with palpebral ptosis dercha that covers the pupil (with right frontal hyperreactivity). No ophthalmoparesis is observed, although it presents diplopia in the upper right quadrant. strength preserved in upper and lower limbs, preserved flexoplantar reflex, no dysmetria or dysdiadochokinesia. Romberg slightly positive.

Keywords: Pancoast syndrome, tobacco, ptosis.

Complementary tests: Hemogram: Hb 11.8 g/dl; 8360 leukocytes/mcL; 65% N; 280,000 Platelets/mcL. Coagulation: INR 0.98 Biochemistry: Glucose 105mg/dl; Urea 36.4 mg/dl; Creatinine 0.78 mg/dl; Na 142mEq/L; K 4.28 mEq/L; Chest x-ray: No pulmonary condensation images.Nodular lesion is observed in the right pulmonary vertex of posterior location. *<u>Interconsulta Ophthalmology:</u> Reflected direct photomotor and obtained conserved. No masses in orbicular flange. No fluorescein lesions, cataracts with cortical and nuclear components. Eye level papilla fund, defined, pale aspect compared to OI. Macula without striking alterations, Vascular arches within normality. Applied retina, vitreous flocs.*

CT Skull: Lesion of 15mm at mesencephalon level that is accompanied by extensive hypodensity affecting the brainstem and extending to the right thalamus, due to edema and tumor infiltration with imprecise edges. No hydrocephalus or hemorrhagic foci are observed.

Diagnosis: Palpebral ptosis secondary to metastatic cerebral LOE of possible pulmonary origin.

Evolution: The patient is admitted to the x plant to complete the study to confirm the etiology. CT chest and abdomen were performed, where a 7 cm diameter lung mass was observed in a coronal plane compatible with a neoplastic lesion. Around the lesion, poorly defined ground-glass density is observed, compatible with areas of obstructive pneumonitis. The tumor contacts the mediastinal pleura without signs of infiltration. Small adenopathies of pathological size. Bronchoscopy: In-depth blind brushing was performed on subsegmental apical LSD without complications. The patient is discharged after 7 days admitted to the hospital. ***Diagnosis: Lung adenocarcinoma with mesencephalon metastasis.***

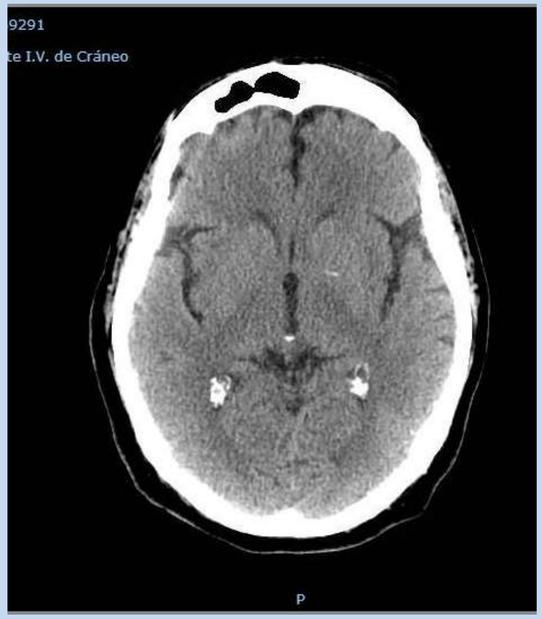
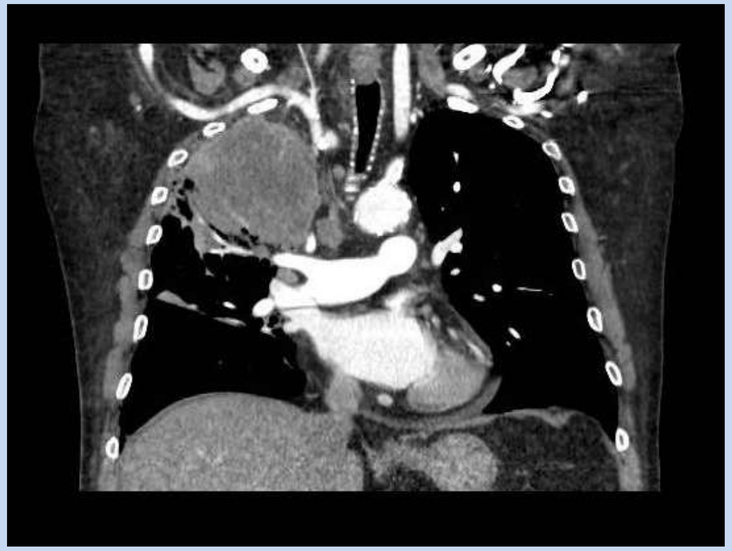


Figure 1 y 2. CT Skull and CT chest



Conclusion: Pancoast syndrome is a set of characteristic symptoms caused by the presence of a tumor in a pulmonary vertex. From the etiological point of view, this syndrome is a consequence of the local extension of a tumor of the pulmonary vertex. Although it may be of any histological variety, lung epidermoid carcinoma predominates (given that this histological variety of lung cancer, being centrally located, is more likely to cause such a picture). Clinically, it is characterized by ulnar forearm pain, chest pain, erosion of the first and second ribs, Claude Bernard Horner syndrome (ptosis, mitosis and facial anhidrosis) and superior vena cava syndrome. In this case the patient did not present my mydriasis or anhidrosis, we decided to carry out an extension study and discard metastasis.